Medication Contract

I, _____, agree to the following rules and conditions regarding refills of prescribed medications.

The medication(s) covered by this agreement include:

MEDICATION	DOSE	DIRECTIONS	QUANTITY PER MONTH

1. I will limit my dose of medications to the dose prescribed. I will discuss any future changes in my dose with my provider.
2. I am responsible for my medications. Lost, misplaced or stolen prescriptions will not be replaced.
3. Refills will be made only at the prescribed level. No early refills will be authorized.
4. No refills with be authorized after-hours, on holidays or on weekends.
5. I will obtain all refills for these medications only at _____ pharmacy (phone number:_____).
6. I will request all refills through my primary care clinic during these hours: _____.
7. I understand that my provider may stop prescribing opioids or change the treatment plan if I do not show any improvement in pain from opioids or my level of activity has not improved.
8. Other: _____
9. I understand that failure to comply with any of these conditions or failure to make regular follow-up appointments with my primary care provider may result in termination of prescriptions for the medications listed above. ***It may also result in being prevented from receiving any further care.***

Signed: _____ Date: _____

Provider: _____ Date: _____